Financial Agreement

Please read entire form carefully, then sign and date the bottom.

The following define the financial policies of the practice.

Payment is due at the time services are rendered

The front desk staff will estimate the amount you owe for procedures the doctor or hygienist has completed or those procedures which are in progress. Remember, this is only an estimate. The actual out of pocket expense may be less than or greater than the amount estimated and collected. You may be reimbursed or apply the excess to another date of service if we have collected too much.

Some insurance plans require the patient to pay only a percentage or co-payment directly to our office. Some plans require the patient to pay the entire amount due for the visit and then reimburse the patient the covered amount. We will work with your plan, and submit the forms necessary to receive the reimbursement as a service to our patients.

Insurance Coverage

We accept many different insurance plans. All plans have a unique schedule of covered services depending on what plan you have or your employer purchased. There is no guarantee that services will be covered. You, or the person responsible for the account, will be responsible for payment of non-covered procedures. There may be additional charges to cover the costs of parts or lab fees, depending on the treatment provided and type of insurance coverage. If you wish, we can send a pre-determination to your insurance carrier. The advantage of this knowing approximately what your out of pocket expenses will be for the procedures. It is NOT a guarantee of payment. The pre-determination takes 4-6 weeks to process.

Major Work

Patients receiving major work, such as crowns, bridges, dentures or bleaching kits must have their portions completely paid off before the work can be delivered or cemented.

Cancellation Policy

Our time is as important as yours. We attempt to schedule as efficiently as possible to reduce waiting time. We ask that you the patient give us 24 hours' notice of cancellation.

Returned Checks

There will be a returned check fee for $20 for any NSF checks. This fee may increase depending on the bank's charges. The fee will be added to the outstanding balance.

I understand the financial policies of Fairbanks Family Dental Care and agree to them.

_____ _____

Signature of Responsible Party Date